MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, January 16, 2003

9:14 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:
Using incentives to improve the quality of beneficiary care
-- Karen Milgate

MR. HACKBARTH: The last presentation will be made by Karen on using incentives to improve quality.

Karen, while I'm thinking of it, is part of your introduction to put this in historical context, if you will, in how we came to this subject? Actually, Dave and I had a conversation last week on the phone and, being a new commissioner, he wasn't quite clear on how we came to be in this conversation. So if you would spend a minute explaining how we got here, that would be helpful.

* MS. MILGATE: I may have had a shorter version, so I'll lengthen it just a tad. I was going to start with the retreat and not our discussions last year, but we could go there, too.

MR. HACKBARTH: Just briefly, I think it would be helpful to go back to last year and explain, very quickly, how we came to this.

MS. MILGATE: This discussion is really a follow-up to our panel discussion in October, most directly, and then also really it's been a progression from discussions we had last year in preparation for our report on applying quality improvement standards in the Medicare program, where we struggled with the concepts of how to apply standards across different types of plans and providers.

So through that discussion we basically, as a commission, came to the I guess conclusion that they needed to be applied differently but that left us in a situation where there was some unevenness in how those standards were applied. And one of the concepts that the commission felt strongly about is that there should be some way of actually rewarding those plans or providers who actually reached a high level performance or else put a lot of effort into improving their performance.

And so we got to the point of recommending that there should be some type of reward for providers or plans, but didn't really get to the next step, which is what would those look like? So in many ways this discussion is kind of a further fleshing out of what would those look like and how would you address some of the issues that may be unique to Medicare and trying to put in place incentives to improve quality.

There was also further a discussion at the retreat about the importance of trying to align financial incentives in Medicare. And then we had the panel discussion in October where, I guess, the takeaway that I heard from the commission from that was it's very important to align incentives in Medicare to encourage quality and it's very difficult to figure how we would do so. I think daunting tasks was a couple of words that I heard coming out of that discussion.

So what we're hoping to do with this discussion today, over

the next few months, and some analysis of current models of how private sector purchasers and payers, as well as public sector purchasers and payers, are using incentives is to shed some light on that daunting task to try to make a little bit less daunting, so we understand some of the complications and perhaps have some idea about the best ways for Medicare to proceed.

So today this is a chance for you to give staff some feedback on an outline and some ideas about how to proceed with these concepts.

So first of all, it's important to define how to proceed? Improving quality is often rewarded through lower costs, through increased volume, so purchasing of better quality products, and sometimes through increased price.

However, in health care that's not exactly how it happens and while quality improvement takes resources and commitment, both staff commitment and executive level commitment to quality improvement as a task, there really at this point are few rewards for putting those efforts in place. Providers and plans certainly get personal and professional satisfaction, they meet regulatory or accreditation standards, but sometimes the entities that actually put in place the quality improvement don't even get any savings from them, if there are savings. And when there aren't savings, when it's a matter of simply investing money, often those improvements aren't well known by either the patients or the payers, or if they are known through some type of public disclosure, often there is not necessarily a mechanism in place to steer patients or payers to better quality providers.

In addition, payment incentives are often neutral or negative. This is certainly true of the Medicare program where we basically pay the same regardless of quality, so that's a neutral incentive. And sometimes, in fact, when quality is worse we pay more. For example, when there are complications in procedures that may be due to the fault of an institution, sometimes the person will get kicked up into a higher DRG and so there's actually a higher payment for a worse quality product.

So why is it important for Medicare to engage in the discussion? In the Institute of Medicine report called Crossing the Quality Chasm, incentives were a big piece of the solution, as part of the national quality agenda that they laid out. And they suggested in that report that Medicare was a very important part of the solution, primarily because they were really the largest single purchaser. So without Medicare it would be difficult and it would be very important to them to take a lead role in trying to figure out the best way to put incentives in place to encourage quality improvement.

And as I noted in my introductory comments, MedPAC also recommended the use of rewards to recognize improvement and performance in the January 2002 report on a applying quality improvement standards.

So how could incentives work? For better performing providers -- and I want to just note when I use the term better performing, it's used in two ways. One is to recognize those that are at a high level performance already? And the second is for those who may start at a low level and actually put some

extraordinary effort into improving their performance. That was also a discussion that we had back in last year which is something that we need to be decided as Medicare goes forth in thinking through what to reward, but that's what I'm meaning, I'm capturing both those concepts.

So for better performing providers, incentives could -- and once again I want to stop to say in terms of incentives. there we're talking about both financial and non-financial. So the concept, at least that I'm presenting here, is that both non-financial and financial incentives could have some impact on the finances of the organization.

The first two bullets really talk about decreased costs and the second two bullets are ways to increase revenue through incentives. The first is shared savings models where you would try to recognize more explicitly the contribution that various providers within a health system make to improving quality. For example, if a primary care practice put in place protocols that kept some folks out of the hospital, would there be ways for those folks to capture some of the savings for the overall health system because they're putting in place the investment to actually improve the quality for their patients ever.

Number two is to decrease the cost of regulation which could decrease the cost to the provider -- I guess that's a fairly obvious one -- through perhaps more focused surveys. So regulators or accreditors could decide to focus more specifically on certain areas where providers were having problems rather than full-blown surveys. Or in one example, CMS in the M+C program has exempted M+C plans that are at a very high level of mammography rates from having to do a national project on mammography.

The second two bullets are basically examples of how incentives could increase revenue. The first is increase volume and that would either be through public disclosure of information that consumers would use. They would then choose to go to the better performing providers. Or not leaving it necessarily to the will of the consumer totally, putting in place some types of financial incentives for consumers to go to better performing providers.

The second would be explicitly recognizing the efforts of the provider by perhaps paying a higher price to those who show better performance.

So clearly there are many design issues in trying to put incentives in place. There's what do we want to encourage, what information to use? Who would you actually try to encourage to do something? And how would you implement the incentives.

In terms of what we would want to encourage, we suggest in the outline that it would be useful to use the IOM framework which has explicit components of quality and that will give us a sense of, in some ways, what type of quality we're encouraging, rather than just using whatever information is out there on particular providers.

So we would suggest focusing on safety, clinical effectiveness, patient perception or patient-centered care -- they're kind of used interchangeably in the report -- and

timeliness. Once we decide what it is we want to encourage, then there are questions that I think I've hinted at, in terms of are you giving rewards for high performance in these areas? Or are you actually trying to get providers to improve so that you will then give them an incentive to improve what they're doing?

And then finally -- and this one depends a little bit upon, I guess, what's actually available -- are you going to measure improvement by looking at the structure, for example? Do you want to give an incentive for health providers to put in place information systems. Clearly, the discussion that began yesterday and continued today, I think from Jack's suggestion is kind of the kind of thing you'd work through there. Are there some kind of structural innovations that the Medicare program can encourage?

Processes are things like the QIO program is looking at, primarily in hospitals where we know that, for example, beta blockers after AMI are a good thing. And so you would measure those and then give rewards for high rates of those.

And outcomes could include things as varied as mortality rates, functional improvement, for example for home health is something that's measured in home health. And one that's less talked about but comes under the rubric of patient perception is, for example, patient understanding of medication once they leave the hospital, is something that has been talked about in some circles.

What information to use? This is one of the most critical pieces and often most well debated in this area. How good are the measures? If you're to distinguish between individual providers and plans you need to make sure that those measures are really good measures and that they're measuring what you think they're measuring, and that you can actually compare across different facilities and providers.

We find, in just our preliminary look at things, and I guess we found this through our report last year that, in fact, measurement is better of some providers than others. So there may be different incentives depending upon who the provider is and how good the information is.

Who you want to incentive depends, I think, a lot on your goals. It depends upon who has the most ability to affect what you want to be affected. It could be at the physician level, hospital level, health system level. So that's something that would need to be decided.

And then how? What is the most effective and simplest to implement? For example, in CMS currently there was article that came out yesterday in JAMA that talked about the successes of the QIO program, at least I would characterize it that way, in actually creating improvement on 20 of the 22 measures that they've worked on.

In that case there's not even public disclosure of the information. It's simply measuring how various institutions are doing on certain measures, feeding that information back to the institution. And I guess I wouldn't credit all of the improvement to the QIOs because there's been a lot of other efforts that have joined those QIO efforts, but I would say it's

one model to use of measuring and feeding back information.

And I wanted to note something else here because I thought it was an interesting thing that I feel like we've already found through talking to private and public purchasers and payers. There seems to be a progression out there, in terms of payers and purchasers use incentives. It seems to be a progression of figuring out how to measure, what to measure, talking with providers so that there is a good buy into what those measurements are. Then a feeding back to providers. And at that point then, payers start talking about maybe we should give this information out publicly or to our enrollees. And then they get to the more difficult but perhaps more effective incentives of financial incentives, either to providers or to beneficiaries.

So it's kind of an interesting thing to consider whether it's actually a continuum of effort, so you don't really plop yourself right up there at financial incentives without going through some of those other steps.

So what types of incentives are we thinking of considering? These are the six that we have identified through some initial analysis, so it was something that I would be looking for guidance on from you all, is if this sums up what you think is out there, if there are other types of incentives that we may have not found in what we've looked at so far.

DR. ROWE: Are these in priority order?

MS. MILGATE: No, they're not in priority order at all.

DR. ROWE: What order are they in? They're not in alphabetical order.

MS. MILGATE: I don't want to say they're in any particular order. I guess that in -- because I would say something that's not right. No, there's no particular order here except the first two are not financial and the last four are.

MS. DePARLE: The first two are things they're already doing. It isn't quite in terms of ease of implementation.

MS. MILGATE: It's not ease of implementation. That's w hat I was thinking but it's not really -- yes, cost differences for beneficiaries would be at the bottom, I think, in terms of ease of implementation. So no, there's no particular order except those are the distinctions, yes.

I wasn't that clever. I should have thought of something.

The first is public disclosure and that's fairly evident. That would either be where a plan would feed information about different types of providers to the enrollees for them to choose. Or the other way that is done, or reason that's done, is often just publicly disclosing the performance of providers for accountability purposes. So it's both for choice and accountability.

Flexible regulation, again, I gave you a couple of examples earlier of ways that you can decrease the costs for providers and plans through flexible regulation.

The third is payment differentials for providers and that would be basically gathering information that you would decide would be a good measure of provider performance on quality and then figuring out ways to actually pay the higher performing providers more.

Cost differences for beneficiaries could be done through cost sharing. Clearly, this is easier done in the private sector than the public sector, where in fact beneficiaries might pay higher amounts if they go to lower performing providers and less if they go to higher performing providers.

Shared savings is a strategy that's been used in some health systems to try to give incentives for different parts of the system, different providers, to actually work together to improve quality. So that the entity that may put the investment in improving quality gets some savings back to themselves, as well as any that may lose money because of quality improvements might be compensated for some of those losses. For example, lower hospitalizations would save money for a health system but would cause the hospital some admissions. That's something that we could debate whether you'd would want to reward or not.

Then the last one is capitation/shared risk. There we're talking about an overall payment incentive that essentially encourages whoever gets those dollars to better coordinate care so that there if, for example, they do reduce hospitalizations for diabetics, that they would get those savings through the shared risk or the capitation that they receive.

So those are all general considerations. In looking at this may be applied to the Medicare program, many issues arise. This is really not intended to be an exclusive list at all. It's just some ideas about some of the more difficult issues that the Medicare program and thus the commission in this discussion would need to think through.

First, it would need to be done different in fee-for-service and the managed care side of the program. So we'd have to think explicitly through some of those issues. Some of the incentives are achievable through regulation. Others would need legislation to implement. So that would need to be considered. And there may be unintended consequences of putting incentives in place. For example, if an institution gets designated as a high quality cancer care provider, they make get all the hard cancer cases. So that would need to be some risk adjustment there that would be adequate to capture those issues.

Access issues might arise. If there were incentives for beneficiaries to go to one provider over another, that could end up in making it difficult to access care in some communities if providers closed or there may be issues about equity, of whether some providers could actually afford to go to one or the other, or travel to go to one or the other.

The third, crowding out of quality innovation is a concern simply because Medicare is such a large purchaser that you would assume that the direction the Medicare program is going, in fact, could essentially become the direction that the nation goes in terms of quality innovation and that would need to be considered to make sure that didn't crowd out other efforts at innovating.

Implementation issues are many but the three that are listed here: one, budget neutrality. Would this be new money for incentives, for the financial incentives, or would there be a taking away from some to give to others? Jack's idea, once again yesterday, about IME intrigued me because it was a mechanism for

creating a pot of money that you would then need to define a product as to how you would then give it to various providers. And I think that discussion highlighted the difficulty of defining the product sometimes and that's clearly true in this area as well.

The availability of skills for a very complex task, trying to make distinctions between providers and beneficiaries isn't simple and Medicare is a large program involving many, many different parts. So it could be a difficult task to take on.

And then finally, the locus of control. We're talking about decisions that could drive the quality agenda for the nation. We're talking about issues about money moving between providers. So there's questions of whether Congress should decide some of these issues, whether CMS should have control, how would the public have input, and those kinds of issues would need to be discussed and decided.

That concludes my presentation, so I'd be interested in your feedback and guidance on the direction of this discussion.

MR. FEEZOR: Karen, as always, your deep depth and interest in this area is quite recognized and I think you've laid out an excellent framework for us to consider.

Just a couple of observations, or a couple of things to track sort of as we look toward some examples of what has helped in terms of public disclosure besides those that Medicare may be involved in, I guess primarily on the SNF side, that we might look at, I guess, if some of the efforts like Pacific Business Group on Health and their efforts at the Leapfrog standards and those hospitals that participated in that might be interesting.

Many of you know or probably have seen that under the category that you had of type of incentives, payment for differential for providers, the six major payers in California will be, beginning this month, they pay for performance. And I noticed, I guess in the recent AMA News or something, that BlueCross and BlueShield of Massachusetts is trying to do similarly some sort of incentives for their specialists. And in addition, there are several of the larger medical groups in California that are trying to move the pay for performance, not just at the primary care level but up to the specialist level.

Under the cost differentials for beneficiaries, a variety of tiered products coming on the line, both those that have sort of what I call more cliff-like behaviors, either you're in the network or not, and strong incentives. And then some that are sort of what I call sort of Zagart measures of four wisps or four dollar marks. And if I choose a four dollar mark hospital, it's going to cost me four times whatever my deductible would be per day of maybe $50 as a way of seeing if that makes any movement.

MS. MILGATE: Allen, have you put those in place?

MR. FEEZOR: We have not. The last one -- and I'm sorry that Alice is not here -- I think BlueCross of California is just putting that up year. Let's put them on our radar screen and try to get more information.

The one thing I did find on your list of six, I would add seven, though it may not pass the test of political feasibility but it's something that I think the current private payers are

going to be revisiting. And that is exclusionary. That's a very perverse incentive. It's maybe a disincentive. Maybe stated more positively would be raising the bar significantly on what minimum qualifications are for participation. Again that hits a political feasibility issue with us, which then, on your last slide, we may want to put -- I don't know whether we want to put it specifically but not far from my mind is considerations in terms of any of these that we might consider.

You said feasibility, I think there's also probably a political sniff test that has to be passed. And then one other sort of consideration for Medicare and for any payer is when I say measurability, we always get stuck in saying well, because we can't measure it perfectly, therefore we don't do it. I think if we think more in terms of accountability to make sure that what we are trying to evaluate does track to the provider of care, whether it's the system, would be a good standard that we need to include in terms of our considerations for Medicare.

MS. DePARLE: I agree with Allen, Karen, that was some very solid work and we appreciate it. And I'm excited about the possibility of MedPAC playing a roll in this debate about how Medicare can move forward more quickly with a quality agenda. As you noted, they're already doing some positive things and I just wanted to highlight one of them and ask actually that you provide the commissioners with copies of the JAMA report, both -- the project that Karen referred to was started in either '98 or '99.

And what CMS did was develop quality indicators with a bunch of clinicians from around the country. And these are not things that are debatable. These are things that everyone agreed this is what should be happening. And then proceeded, I think for the first time in fee-for-service Medicare, to gather the data for each state. So on a state-by-state basis we have data now on what Medicare beneficiaries are getting and what they're not getting. Senator, as usual, Minnesota does very well.

MR. DURENBERGER: And Montana and North Dakota.

MS. DePARLE: It's also interesting when you match that up against payments from Medicare to the states on a per beneficiary basis. So we could have that debate, as well. It's very provocative, very interesting data.

But it was not an each easy project for the agency. It has not been an easy project and Dr. Jeff Kang and Dr. Steve Jenks led that effort. And the report that came out yesterday showed some improvement. I was pleased to see the reaction.

This was a bit of a yawn when it came out in September of 2000, the first report. But for example, I remember that it said that New Jersey ranked very, very, 45th or 46th among the states in achievement of these quality indicators. And the New Jersey Medical Society stood up and said this is unacceptable. We want to improve. And they did show some improvement.

So that, at least, made me hopeful and I think it's the kind of thing that the commission should encourage, as well as the other efforts that CMS is engaged in right now, to publicly disclose a lot of this information.

And I would even support disclosing what they have now, on a more granular basis. But that's a difficult thing. And we

didn't do it while I was there, so it's easy for me now to say they should do it. I admit that.

DR. ROWE: Just four comments. We found it helpful in our quality initiatives in our company to focus on special populations rather than -- you know, there's more to quality than HEDIS. And two populations that I think Medicare might consider as part of the quality problem are care at the end of life and racial and ethnic minority disparities in care, which I see as not a civil rights issue but a quality of care issue. And I think that there are a lot of data and there are a lot of disparities. There's a disparity behind every tree and under every rock. We don't have to do a lot of research to find more disparities but we should be able to target them specifically.

So I think there's an opportunity that Medicare has that I'd like to see. At least those are two populations.

Secondly, you made mention, Karen, early on of the fact that the people who make the investment aren't always the ones who gain. Don Berwick made that point when he joined us sometime ago and gave that presentation. I think that's true and its interesting, but you might make note of the fact that that's not necessarily relevant to the Medicare situation because the company invests in it and the health plan saves, or the health plan invests in it and the company saves because people have fewer days out of work and the company has to hire fewer temporary employees.

And some of those analyses that Dr. Berwick did aren't really relevant to what Medicare is doing and, in fact, we're paying both the hospital and a doctor and we're not counting work productivity as one of the outcomes et cetera. So some of those analyses are not necessarily germane. Some are.

Third, is the issue of your list of approaches, you didn't include what to me is the most obvious one and maybe it's the most combustible one and therefore you didn't want to step on it and I don't blame you for that. But there is a simpler approach than trying to figure out whether you should pay certain providers more and that is, of course, not to pay some at all. And that is to restrict your network based on quality.

It's not easy to do but you know -- and there are areas in which there are limited number of physicians, et cetera, but just include them.

And then the last thing has to do with efforts, the co-variants, if you will, I guess, of efforts to improve quality and efforts to improve education, which was commented on in some of the discussion earlier today and yesterday. And it might just be noted that if Medicare does really decide that it's a proper utilization of these resources that we have for the program to improve certain underlying initiatives such as information systems, to get computerized order entry in all hospitals and stuff like that, that that will also improve medical education and facilitate more effective training and stuff like that. So there might be some mention of the fact that there is some synergy with respect to well targeted education and quality initiatives. Thanks.

MR. DURENBERGER: I'm glad Nancy-Ann reminded us, because I

wanted to begin by recognizing that without her, this initiative that got reported yesterday would not have happened and a whole lot of other things that people are doing voluntarily in the private sector to try to get a definition of quality would not have been encouraged because a lot of people knew what she had committed CMS to do. So I'm pleased that you explained it so that I could tell you how much your decision meant to those of us who have been working on this issue.

Second point, Karen, this is just a great outline, and particularly the three or four page outline that I worked with which was the design of the detailed outline. And I intend to respond to that in some detail, and I won't try to cover it in my remarks.

The first point I wanted to make is I think we should talk about this in the context of these other papers we're doing, as well. We're doing papers on spending and the issue is spending on what? Just paying for providers or are we paying for something else? And it should be raised as an issue when we're talking about access which is access to what? And it should be raised when we talk about choice as a factor.

So it would behoove us, in everything that we do, to focus on the importance from a beneficiary standpoint of paying for what? Not just the prices that we're paying, but what are we buying with our money? Secondly, there's a comment in there somewhere about Medicare in the past not capturing savings and Nancy's already made the point that I would illustrate with a map that was in the Post yesterday. Medicare has captured a lot of the savings that came from the Northwest, the Upper Midwest, New England, and so forth because it kept driving down the payments in the fee-for-service system as back in the 1980s when we did the TEFRA risk contract.

As the behavior changed in heavy concentration of HMOs, the spillover effect on fee-for-service, in effect, took the whole part -- and there's a researcher up at Marshfield Clinic who's done a beautiful job on this map -- that the upper Midwest, for example North Dakota was one of the worst, was in the first or the upper quartile in terms of Medicare payments per beneficiary in the early 1980s. By the early 1990s, North Dakota was in the lowest quartile and in large part it was because of the impact on fee-for-service of the work that was done under both cost contracts and risk contracts. And I know there's some debate over cause and effect on that issue but his data from the early '90s shows all of the same areas that are black or high-quality here today are also the low pay areas today by comparison with 10 or 15 years earlier. So somebody made that money and it wasn't the HMOs and the providers. I think it was -- I think, at least in the early stages of it, it was the Medicare program. That's just a matter of my version of the record.

The second thing that I would hope you would build into the process, and that is looking at efficiencies in process as well as the results or the outcomes. I think in terms of empaneling people and bringing experts together you might be well advised to get the management experts, some economists, some people who have worked with the process of care design and delivering, as well as

folks that might be -- and you don't have to get just health economists or people that manage health organizations to do it -- but adding the dimension of efficiency to this effort to pay for performance and quality and so forth gives you a dimension that rewards the Billings Hospital or the whatever it is that is spending and investing the money in processes that support more appropriate care delivery as well.

The third one is sort of along that same line which is to evaluate not just -- I'm in section number three, which is the design issues -- to look at some processes and portions of processes to get to a particular end and to look at those as ways in which to reward the end that you want, not just looking at the end itself.

The last one is this, which is we have a tendency to look at a solution. Let's pick one of the six or something like that, and that will be the Medicare approach to it. But in many of our communities, the challenge is this, how can we equip consumers to make demands on providers even though they don't want to leave those, or they can't leave those providers. Let's say you're in so many communities represented here where you don't want to leave the provider and so yo don't have exit as one of your options, you only have voice or demand or something like that as your option. How can we, on that kind of a level equip people to make demands on their providers? The point simply is there isn't one solution. There ought to be some smaller ways in which we might deal with it.

But as I said, I'm going to put this all together in a written document and send it to you, as well.

DR. NEWHOUSE: I know we don't usually have recommendations in the June report, but I'd like to suggest that where we might head is to encourage some kind of controlled experimentation in this area with the Medicare program. It's clear from what everybody has said and what Karen has written that Medicare is such a big piece of the action -- and many would say a big piece of the problem -- that it's important that Medicare do something here. It's also clear from Karen's last slide, there could be lots of unintended side effects that would make things worse, depending on how it's done.

In light of that, it seems to me the way to proceed is to try to learn something about what various things do. There's lots bubbling up in the private sector, has people have said, and we'll see how well that gets evaluated. It may or may not be applicable to Medicare.

One other elaboration on Jack's point, it's clear that Medicare has some incentives to invest in, for example, preventive measures that don't apply on the private side. But where I think there is a problem with Medicare in the quality areas, among several other places, is in the hand-off coordination side of Medicare across sites. And I think our payment systems that are geared to site-specific payment just encourage that kind of problem. Or put the other way around, discourage trying to coordinate. The kind of obvious policy initiative in the Medicare area that would serve this area is M+C where the plan in principal could have incentives to coordinate.

We may want to think about a link there, but given the anemic state of M+C, we also should think about ways to improve incentives for this in traditional Medicare.

DR. STOWERS: Again, Karen, great chapter.

I just wanted to -- we were talking about rewards, incentives and that kind of thing. And I think sometimes we need to step way back and put some kind of a reward or incentive or covering the cost or whatever of just collecting the data.

You know, we're putting together a national rural hospital database right now that includes financial incentives, patient and staff satisfaction numbers, and several evidence-based measures. And yet what we're finding is that these individual providers, hospitals, rural home health, that kind of thing, see tremendous value in just receiving benchmarking back of how they're comparing there and how they're doing. They actually have a very high incentive to improve the quality in their communities, but in many times they lack the resources to collect this data and so forth. And there is a cost associated with that.

And I think this could even be carried down to our individual physician offices that are on fee-for-service, where if there was some incentive in the Medicare program to provide this data and then where physicians could receive benchmarking back -- I know that's happened in certain health plans and that sort of thing, but we've never been able to reach the masses with that kind of feedback and data.

So I think somewhere along the way we're going to have to put a value on the data that is collected and some kind of an incentive for that to it occur, or at least cover the cost of that occurring which does not happen under our current program.

So if you see incentives up there, I think just somehow covering the cost or whatever. I think as electronic medical records come in, we cover that kind of thing. We've developed some new systems. It's getting much simpler to extract out the data that you need to do that but there's some costs that some cannot cover to do that.

MS. MILGATE: I also hear you saying, in addition to covering the cost, that one type of incentive may simply be feeding back useful information to the provider and maybe that's another incentive we should also --

DR. STOWERS: I'm glad you picked up on that because I think that there is an underlying desire out there to improve the quality of care being delivered. I believe that. But I think what we fail to provide is that we collect all of this data and we do not get it back to the individual provider level, the individual physician, the individual small hospital, the individual agency.

So the umbrella data is fine but we have to get it back to the individual provider. And there is a value in that that I think we have to not lose track of. But we can collect it until we're blue in the face, but if we don't get it back to the provider it's not going to create much change.

MR. HACKBARTH: Can I just pick up on that point? When you were talking about the report in JAMA you said that some of this

effect may not be attributable only to the QIO effort and I think that's right. I think in some of these areas is that clinicians, providers are hearing from public and private payers, from the professional societies, that these are priority areas. So it's the fact that we're pushing in the same direction that helps.

I know when I was involved in Boston in a large medical group, the most frustrating thing was when everybody was pulling us in a different direction. Every different payer had a different set of priorities. We want to do ours now. And that's just maddening.

When people come together and say, at a professional level, here are well-defined clinical standards and they matter to a large group of different payers, boy that's a relief and you know what to focus on. At that point, the incentive issues and payment issues become a lot less because clinicians want to get better and they just want to have a focus.

DR. STOWERS: I just want to throw one more pointed in. The other thing we've been trying to do is link accreditation requirements and those sort of things actually to the data that's been collected because that is a tremendous burden on both sides with the quality initiatives and then the accreditation process. And right now those two are sitting at absolute other ends of the pole.

So I think if we can somehow, as an incentive, link accreditation or standardization to the data that we're trying to correct, so that it has more than one purpose in the system.

MS. RAPHAEL: Very briefly, I wanted to second what Joe recommended, which is I think we should not be spending five years designing the perfect system here. I think we need a period of experimentation, recognizing that some of the approaches we try will not pan out or will need to be modified. But I do think we need to get going.

And I do think there is this issue about how to make this less overwhelming and really kind of give people the sense that you have the organizational capacity to take this on.

I think Jack's point on trying to deal with one population is a good one, because if you can do it for diabetics you get the sense that you can then take what you've learned and the whole methodology and move it on to another population.

I was also interested in your process because I do think there is a process here that's happening, which starts with getting information back, giving feedback, teams kind of using that to change what they're doing. And then that really kind of sets in motion a whole trajectory which could end with financial incentives. I don't know that it begins with financial incentives. So I think that's important.

I'd be interested, if there's any evaluation of CMS's public disclosure efforts in nursing homes, and I know they're moving to home health care. We've heard anectdotally that it's affecting providers much more than consumers, but I'd be interested in trying to get a better understanding of what effect that has had. Because I think one of the points you made is important. We often look at this from the provider end, clinical effectiveness, safety. But I think we should not lose sight of the consumer

end.

I don't know what levers we have on the consumer end. I know that the things that they value, responsiveness, timeliness, good support and information, are very different from the things that we as providers often focus on. And I'd just be interested in what we know about how to influence consumer behavior, if we really have any clear understandings in that realm.

DR. REISCHAUER: Karen, let me add my compliments to those of the other commissioners for a really nice job, and say I, like the other commissioners, think it's absolutely essential that Medicare play a leading role in the quality effort and that we should emphasize that very significantly.

I'd also urged that while it might not be a recommendation, we urge Congress to make some clear endorsement of CMS moving in this direction, because this is the kind of thing that unless Congress is on record saying something it will be undermined quite easily by individual members reflecting the interest of providers in their area.

I heard Joe, I guess, a little differently from how Carol heard him because I was a little distressed when he said well, some experimentation and demonstrations. I immediately thought that I will become eligible for Medicare, benefit from the program, and die before anything happens here if that's the way we go. I think there's enough information, examples from the private sector, whatever, to move ahead in certain areas now while at the same time we try and beef up our knowledge base and go forward. And we shouldn't try and wait for some more comprehensive approach to this or something that's neat and all fits together in any kind of way. I want to see Medicare going forward.

With respect to some of your reservations along this line, I see them used as excuses for delay. And when I think about is this budget neutral, how do I go about this, I think every year we're sitting here providing a lot of updates. And the updates come with great precision, 3.4 percent, and we've subtracted .9 for multifactor productivity. We're really dealing with some pretty squishy stuff here and it would be quite reasonable to say we think the update should be 3.4 percent but .1 of a percent this year is going to be reserved for a quality fund. And over time, as our knowledge base and our ability to do this builds, this .1 of a percentage point each year will become real money. So I don't want to get hung up on the sort of budgetary aspect of this.

Carol raised another point which I was going to emphasize, which had to do with your unintended consequences which also can be seen as a reason for delay. What we know, I think, from cardiac care and some other areas is that consumers are dumber that a stone when it comes to reacting to qualitative information that's put in front of them. You can say that you go to hospital A and your chance of dying is 10 times what it is if you go to hospital B and they all still go to A.

We should raise those issues but we shouldn't leave what evidence we have that suggests that they might not be huge factors not discussed.

Finally, I see there is a real problem here with respect to the geography of Medicare. We can go about this in some absolute sense or in a relative sense or a combination of the two. And I would argue for the combination of the two. If we had measures of quality of care for complex procedures, it might be that that the facilities capable of achieving the high quality exist only in certain parts of this country. And if you began rewarding that kind of behavior, you've created a problem for people who represent geographic constituencies.

And so you can do a dual reward system which says we're measuring quality within this geographic area and giving bonuses to the most improvement within the area or the best level within the area and based on a national basis but you want to be very careful in how you do it considering the complex geography of our country.

MS. DePARLE: Karen pointed out, you can choose to do -- having high-performance and/or improvement. So surely, even if there are areas that start at a different place, they would show improvement.

DR. REISCHAUER: I have a problem, in a sense, with improvement because what you're doing is then maybe rewarding, in a sense, the biggest polluter. And it has to be for a very short period of time. There has to be expectations that everybody should reach a certain level.

MS. DePARLE: You've been away from Capitol Hill too long because I agree with you and this isn't where I would --

DR. REISCHAUER: There's no such thing as being away from Capitol Hill too long.

[Laughter.]

MS. DePARLE: Touche. But I think that we have to start somewhere, and for the very reason that you described it will be difficult to go down this road. But if this is a way to get started and to get everyone on the same page, and as Ray says, I believe clinicians and people who work in health care want to improve. If that's a way to get started and for the Senator's former colleagues to embrace this, let's go.

DR. WAKEFIELD: It sounded to me, Bob, like you might be talking about trading pollution credits, when you were talking about the clean air, that maybe the equivalent to that is trading quality credits instead of trading pollution credits.

Just a few quick comments. One is that I think, at least in my mind, it isn't -- in terms of where services get provide it isn't so much that everyone ought to be doing exactly the same set of services and so referral to large facilities and specialty facilities is wholly problematic. I don't think that is. I think the issue, for me, coming from a rural area is that what is done inside facilities, whatever it is, is done extremely well and it's not handicapped by lack of infrastructure or technology and so on.

A thread that I think is going to run through a lot of this is availability of that infrastructure. The technology, therapeutic, sufficient information infrastructure, diagnostic technology, therapeutic technology, et cetera, to do whatever it is. If it's to take care of that 75-year-old that comes in with

community acquired pneumonia or something else. But that we really keep a firm eye on what the basic infrastructure is and that we don't run into some of the problems that you might be getting at, Karen, with the question about will steering beneficiaries to one provider over another create access problems.

I think as long as we pay attention to access to that basic infrastructure and that if we're talking about community hospitals having a reimbursement that allows them to have an infrastructure not unlike teaching hospitals having a reimbursement that allows them to have infrastructure, as long as we're looking at reimbursement that allows that, the human and technology infrastructure resources to be there -- again, not so everyone is doing heart transplants but so whatever that care is that is being provided across the board is high quality care.

Secondly, just in terms of reporting measures, think back 10 years ago. We're in a whole new field in terms of what's happening with access to reporting and how it might be incentivizing or not, where beneficiaries choose their care, or how providers perform.

It might be worth looking at, even though lots has been done in that area, whether or not there might be more incentives to reporting additional measures, recognizing that there are costs for gathering information, collecting it, and aggregating it and making it useful for consumption. But the question might be is there a more granular level that we ought to be reporting out? Or should we be casting the reporting net even wider thinking even more broadly than we are right now about what gets reported. So it might be a level of specificity or it might be greater breadth, not just depth.

Another comment is to really pay attention, thinking about the levers that we've got. I think that the notion of making major changes and demonstration project efforts are not mutually exclusive. So while we won't see a whole change necessarily tomorrow that we'll all benefit from in terms of quality improvement efforts, we certainly ought to be pulling from the private sector what we can and using it where it makes sense.

We should also be pulling new information, I think, from the work that foundations and the others have supported. That may be relevant, I don't know, I haven't looked at it in this context. But like Pursuing Perfection, being financially supported through RWJ, and so on. What are private payers doing?

But in addition, what's coming out of some of these more targeted quality efforts that are supported by foundations? Anything there that we could learn to inform our thinking in the Medicare program?

And I would say let's look at demos, not to be timid but to say to the extent that CMS has demonstration authority, can we try and move that vehicle even more than it has been recently on the quality agenda?

I guess the last point I wanted to make is that when critical access hospitals, as that program has started to unfold in rural areas, it was wrapped around with incentives to focus heavily on quality and emergency care.

On the quality front, this program has been up and running long enough now for a period of time, and spread to enough hospitals, that there might be something to be learned from what's been done with that quality agenda that was basically placed as an expectation on hospitals that were converting to CAH status. So in other words, I'd look there to see, in the tracking project that's been underway now for at least a couple of years, what is it if anything, we can learn?

Last point on the QIOs, I'm not sure -- when we think about small hospitals, that don't have a quality improvement and quality assurance infrastructure of a Beth Israel or a Mass General or whatever, but probably have to rely, if they're willing to, on the QIOs to help them with QI efforts. I'm not sure, and maybe it's for somebody else to decide, but I'm not sure about the extent to which we're adequately resourcing QIOs to do the work that I think clearly needs to be done in terms of assisting small providers. And I know there's been some expansion of that portfolio of late. But again, that's another lever that obviously Medicare has readily accessible. Is there anything else we should be thinking about, in terms of moving that lever?

MR. MULLER: I'll echo the previous congratulations on this very excellent report. Just as there's enormous variation of health care in this country, I think we're also seeing that there's enormous variation in that wonderful taxonomy that you provided of the quality initiatives.

In the spirit of both urging us to move forward on this, and focusing on it, I would suggest that our focus be on disease areas that are either high incidence or high cost, and specifically heart disease and diabetes and renal and mental illness.

I think some of the themes that have been discussed today, whether it's Joe's theme about looking at payment systems across sites of care, whether we look at systems of care versus just a focus on individual practitioners, whether it's the question of how to use evidenced-based medicine to best promote care. I urge us, as we look at both the June reported and beyond, to look at those disease categories because obviously in our role as a payment commission they are the ones where there are large costs. And I think there's now evidence, both around the country and around the world, that in these areas major advances can be made by getting people to work on a more common set of protocols, not to try to drive out all variation in care -- I agree that's one of those combustible categories that Jack mentioned earlier -- but there's enormous advantage to be secured by having -- whether it's as simple an example as the beta blockers after AMI -- there's enough evidence now around the world and in our country to know that major advances can be made in that area.

So I would urge us to focus on our quality initiatives. This is the area I think we should focus on. And I think both an enormous advantage can be made in terms of quality and enormous advantage in terms of costs by taking the best evidence we now have, both in the literature and in practice, and using it inside the Medicare program. And using the kind of muscle of Medicare

to move behind these large disease areas I think would be the most fruitful way to go.

DR. WOLTER: Very quickly, I think there are a number of people who have been thinking about this topic quite a bit. For example, I think the IOM has a subcommittee looking at barriers to creating the idea health system of the future. I don't know if you've talked to those folks, Karen, but one of the specific barriers they've looked at is the incentive system currently in place and it might be worth visiting with them and seeing what they've put together.

Also, it's my perception that CMS really is playing a leadership role currently in this mess. And for an agency that is often under a great deal of criticism, I think in many ways they're way out front of Joint Commission and a number of other agencies, et cetera.

Also, I would say that they're doing things beyond the QIO. For example, they recently put out an RFP for large group practices to put together a program looking at care of Medicare beneficiaries over the course of a year or longer in which utilization cost data, and then also certain quality parameters, would be analyzed. And they built in some incentives such that, depending on your overall hospitalization rates and certain quality parameters, there could be a return of dollars even over and beyond what you might receive in terms of fee-for-service payment.

So somebody has put a lot of thought into this and we might be able to tap into that, in terms of how we build on it.

And then, just lastly, I think the tone in the June report, as far as CMS goes, might be to somewhat congratulate them for the leadership they're providing and then urge Congress to continue to resource the good work that they've begun.

MR. HACKBARTH: Good points.

Okay, I think we are done.